



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

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COMMONWEALTH of VIRGINIA
Department for the Aging
 Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
 Area Agencies on Aging

FROM: Tim M. Catherman
 Deputy Commissioner, Support Services

DATE: June 1, 2005

SUBJECT: Virginia Aging and AoA in the News

Below are Virginia Aging or AoA related articles that have occurred since last week's Tuesday E-mailing. These links do not require a paid service; however, some (like the Washington Post, etc.) ask a brief survey or registration. Please note some links are time sensitive and can change daily. Some articles may be editorial and/or political. Links are presented 'as is'.

If you are aware of additional articles, please e-mail me a link for inclusion next week.

Virginia AAAs In the News

[Community briefs jm](#)

Potomac News (subscription) - Woodbridge, VA

The Prince William Area Agency on Aging has positions open in the Senior Community ... 2004 Michael Allen Hoffman Award from the Council of Virginia Archaeologists ...

[Healthy seniors mean more challenges](#)

Loudoun Times-Mirror - Leesburg, VA

... said Anne Edwards, division manager of the county's Area Agency on Aging, the public ... A recent study conducted by Virginia Tech estimates that "by 2020, more ...

AoA in the News

[Winners Named in Older American Photo Contest by Administration on ...](#)

SeniorJournal.com - San Antonio, TX

... of Tuscaloosa, Alabama, with "Focus on Senior Citizens Center." Winners are being honored tonight in Washington DC by the Administration on Aging as part ...

1610 Forest Avenue, Suite 100, Richmond, Virginia 23229

Toll-Free: 1-800-552-3402 (Voice/TTY) • Phone: 804-662-9333 • Fax: 804-662-9354

E-mail: aging@vda.virginia.gov • Web Site: www.vda.virginia.gov

Virginia Aging and AoA in the News
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[Advocate for Senior Citizens -- Protecting Against Abuse and ...](#)

Emediawire (press release) - Ferndale, WA

... According to the '2002 A Profile of Older Americans' published by the Administration on Aging (<http://www.aoa.gov/aoa/stats/profile/4.html>) 41% of women ...

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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen M. Nau, Human Services Program Coordinator

DATE: May 31, 2005

SUBJECT: National Family Caregiver Support Program

The ***Virginia Caregivers Coalition*** has produced **Taking Care: A Resource Guide for Caregivers**. The Virginia Caregivers Coalition is composed of public and private organizations as well as individual caregivers. The 57page guidebook is now available at VDA, in limited quantities, to organizations that provide information and support to family caregivers. The guide is also available at the VDA website at <http://www.aging.state.va.us/pubtitlelist.htm>.

Caregiver Training

Crater Community Hospice will provide a **Caregiver Training, Living and Loving Fully Through the Changes that Life Brings** beginning June 21st and lasting for five consecutive Tuesdays through July 19th. The trainings will be conducted from 11:30 A.M. to 1:00 P.M. at the Johnston Willis Campus of the CJW Medical Center at 1459 Johnston Willis Drive Richmond, Virginia 23235. Topics featured at the training include:

- The Caregiving Journey
- Legal Matters
- Delighting in Your Relationship
- Experiencing Love
- Meaning in Life and Dying

The training is free but space is limited. For reservations, call Karen Gill, LCSW, at Crater Community Hospice (804-526-4300)

AARP Virginia – Public Hearings on Long-Term Care

AARP is conducting a multi-year campaign to increase consumer choice for the delivery of long-term care services in Virginia, expand home and community based services,

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National Family Caregiver Support Program

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enhance quality of services and improve access to services. The first part of this campaign is a series of public hearings where the citizens can recount their experiences with long-term care and express their opinions on how these services should be delivered to consumers. Future hearing will be held at:

- June 8 – Cedar Bluff – Southwest Community College, Claypool, Virginia 9:30 A.M. –12:30 P.M.
- June 8 - Danville – The Crossing at the Dan (Farmer's Market) 1 P.M. – 3 P.M.
- June 9 – South Hill – Town Office Building 211 S. Mecklenburg Ave. 1 P.M.- 3 P.M.
- June 14 – Chesterfield County – Church of the Epiphany 11000 Smoketree Drive. 7 P.M. – 9 P.M.
- June 16 – Newport News – Midtown Community Center – 6:30 P.M. – 8:30 P.M.
- June 17 – Salem – Salem Civic Center – 1001 Boulevard – 9 A.M. – 11 A.M.
- June 17 – Eastern Shore – Market Street United Church 75 Market St. Onancock 1 P.M. – 3 P.M.

For further information, contact Brian Jacks at AARP Virginia. BJacks@aarp.org

Alzheimer's Association Greater Richmond Chapter

Mary Ann Johnson, Program Director of the Greater Richmond Chapter of the Alzheimer's Association announces a series of training for professionals and caregivers.

ABAC (Alzheimer's Based Activity Care) June 9, 2005 8:30 A.M. 5:00 PM at Our Lady of Hope 13700 North Gayton Road Richmond, VA 23233

A training for persons who have at least 2 years of experience coordinating a dementia unit.

\$60.00 per person, call 804-967-2580 to register

Nurturing the Spirit June 7, 2005 9:00 A. M. – 1:00 P.M. Porporone Baptist Church RR 14 Shacklesford, VA

A workshop for clergy, lay leaders and visitation committee from faith based organizations.

\$10.00 per person, call 804-967-2580 to register

Putting the Pieces of the Puzzle Together June 11, 2005 8:30 A.M. – 3:30 P.M. Ginter Hall West 12411 Gayton Road Richmond, VA 23233

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A workshop for care partners of persons with dementia.

\$10.00 fee per person, call 804-967-2580 to register

Person Centered Care Training June 21, 22, 23 1:00 P.M. – 5:00 P.M.
Bon Secours Retirement Facility at Ironbridge 6701 Ironbridge Road
Chester, Virginia

A 12 hour professional training for persons caring for those with memory impairment.

\$20.00 per person, to register call 804-967-2580

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MEMORANDUM

TO: Executive Directors
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FROM: Tim M. Catherman
Deputy Commissioner, Support Services

DATE: June 1, 2005

SUBJECT: MS. VIRGINIA SENIOR AMERICA

Attached is a press release from Pinky O'Neil, Public Relations Director and Ms. Senior America State Director, about the 21st Annual Virginia Senior America Pageant.



FOR IMMEDIATE RELEASE

**BEVERLY A. WETHERBIE OF ALEXANDRIA
WINNER OF 2005 MS. VIRGINIA SENIOR AMERICA
21st ANNUAL PAGEANT**

BEVERLY A. WETHERBIE OF ALEXANDRIA, VA, WAS CROWNED THE 21th ANNIVERSARY MS VIRGINIA SENIOR AMERICA 2005 AT OAKTON HIGH SCHOOL, VIENNA, VA, SATURDAY, MAY 14. SHE WILL RECEIVE AN ALL EXPENSE PAID TRIP SPONSORED BY FALLS RUN by DEL WEBB OF FREDERICKSBURG TO COMPETE IN THE MS. SENIOR AMERICA PAGEANT TO BE HELD IN LAS VEGAS IN NOVEMBER. SHE WILL BE THE GUEST PERFORMER FOR THE MVSA CAMEO JEWELS UPCOMING PERFORMANCES.

WENDY PINHEY OF ANNANDALE, WAS 1st RUNNER-UP AND MS. CONGENIALITY; SUZANN HOWE OF BURKE, 2nd RUNNER-UP AND SHE RECEIVED THE 6TH ANNUAL COMMUNITY SERVICE AWARD. BETTY ANN GRAVES OF ALEXANDRIA, RECEIVED AWARDS FOR THE MOST ORIGINAL TALENT AND MOST ADS SOLD. BARBARA JACKSON,

**VIRGINIA BEACH, THE MOST INTERESTING PHILOSOPHY OF LIFE AND
PEGGY GOWER, CHESAPEAKE, THE BEST EVENING GOWN AWARD.**



THE MVSA PAGEANT PRESENTS THE POSITIVE SIDE OF AGING TO THE PUBLIC. THE CONTESTANTS SERVE AS ROLE MODELS TO THEIR FAMILIES, THE COMMUNITY AND YOUNG PEOPLE. WOMEN WHO HAVE REACHED THE 'AGE OF 'ELEGANCE' 60 YEARS AND BETTER WHO HAVE LIVED IN VIRGINIA FOR 6 MONTHS AND LONGER AND ARE U. S. CITIZENS ARE ELIGIBLE. THE TRAVELING ENTERTAINMENT TROUPE 'CAMEO JEWELS' PERFORM AT SENIOR CENTERS, NURSING HOMES, HOSPITALS AND COMMUNITY EVENTS BRINGING JOY AND HOPE TO AUDIENCES.

INFORMATION REGARDING MS. WETHERBIE TO BE A GUEST SPEAKER AT YOUR SPECIAL EVENT OR HOW TO ENTER MS. VIRGINIA SENIOR AMERICA PAGEANT 2006 CALL: PINKY O'NEIL 703-481-1715 OR EMAIL PINKYON@AOL.COM

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Pinky O'Neil

Public Relations Director, Ms. Senior America
State Director
Ms. Virginia Senior America Pageant
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MEMORANDUM

TO: Executive Directors
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FROM: Ellen M. Nau, Human Services Program Coordinator

DATE: June 1, 2005

SUBJECT: Best Practices in Care Coordination – A Case Study

The following narrative illustrates an excellent example of care coordination. The client's name and other identifying factors have been changed to protect his privacy. Notice the total involvement of private entities, doctors, service agencies, client friends and family coordinated by the case manager, Mary Jane Pease of the Prince William Area Agency on Aging, who provided VDA with this case summary.

Artist, musician, collector, pilot and nature lover...Edison was all that and more. I became his Care Manager in August 2004, when I went out to his home to do a formal assessment for services after a referral from DSS Adult Protective Services.

At age sixty-six, he was battling a fatal illness and fighting hard to maintain his independence. He had been diagnosed with Amyotrophic Lateral Sclerosis (ALS), Bulbar Onset, in July 2003. This condition left Edgar unable to speak or swallow and required insertion of a peg tube for feeding. He communicated by writing, gestures, or by limited use of a speech synthesizer which was difficult for him to use, and which he eventually abandoned altogether.

His fine motor skills were increasingly affected. He had bursitis in his left knee and was beginning to show problems with walking. He used a cane for support and his teeth were in terrible condition. He had a history of Transient Ischemic Attacks (TIAs) in the early 90's and then a major stroke in 1995 severely affected his ability to manage his own financial affairs. His son reported a past history of major alcohol abuse (not a current problem).

Best Practices in Care Coordination – A Case Study

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The UAI assessment process revealed he needed assistance with bathing, dressing and eating in addition to needing mechanical help with walking and assistance with mobility. He also needed assistance in most Independent Activities of Daily Living (IADLs). He was alert and oriented and very strong-minded. Although he acknowledged feeling anxious and sad most of the time (“I have ALS, you want me to dance?”) he was willing to accept a referral for mental health counseling. Medication management also turned out to be a problem.

While reviewing his caregiver support system, I learned Edison had one child who lived in another state, the product of his first marriage that had ended in divorce in 1975 when his son was young. They were not in close communication. He had two devoted friends (husband and wife) who were godparents to his son. Although they visited and helped him out in many ways, they lived in the next county and had their own health and work issues.

Financially, he was in trouble. Once very meticulous in his record keeping, he was now having a great deal of difficulty paying bills and managing his money. Socially, his life was lonely and at age sixty-six, he still wanted to share his many interests with a companion despite the many barriers he presented.

His personal appearance was sometimes that of a “street person” because of stains and remnants of spilled liquid food and excess saliva on his beard, clothing and boots. His hair and beard were long and unkempt. It was not easy to detect the bright mind and strong will of the man inside.

My task was to pull together as many resources as possible to address his special issues: ALS and other medical conditions, housekeeping, nutrition, mental health, legal matters such as POA and advanced directive, finances, companionship, hygiene, planning for future living arrangements and involving his son in an active role.

In order to implement my Care Plan, I established positive working relationships with the client’s informal caregivers, his son, his former spouse, the local bank manager, and his apartment manager. I sought out information, resources and services from the ALS Society, the medical clinic at a University Hospital and Veterans Affairs. Other local resources used included the Parish Nurse Program; a home health agency; an Urgent Care Medical facility; Legal Services; and Prince William Area Agency on Aging’s emergency funds, loan closet and Friendly Visitor Program.

Best Practices in Care Coordination – A Case Study

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Our Supportive Services for Adults team was invaluable because it allowed me to pull in the expertise of other PWAAA long-term care professionals, the Geriatric Specialist from the Community Services Board, a nurse from the Health Department, APS workers from Department of Social Services, and a local social services worker ...all team members! Our weekly meetings provided opportunities to brainstorm.

By the end of February 2005, Edison was becoming less able to take care of himself and had two serious falls in his bathroom requiring emergency medical treatment. He was losing control of his hands and dropping things more. I was able to obtain a \$1000 grant from the ALS society for home care assistance, but projected that it would only last through the end of March. I knew I could not guarantee any home care assistance after that until at least July 1, when our agency would begin a new budget year. I began pressing his son very hard to find a nursing home in his state ASAP.

On March 9, his son informed me that he had located a nursing home about 10 minutes from his home that might be appropriate. I followed up with phone calls to the nursing home; the son's local Area Agency on Aging; and the community based services agency that handled Medicaid there. I faxed an updated UAI and continued to advocate for Edison's admission. I also re-contacted Edison's separated spouse to obtain financial information to help the client establish LTC Medicaid eligibility.

Our efforts culminated in a group meeting on March 12, when his two caregivers and I joined Edison in his apartment. We used my cell phone on speaker mode to include his son in the conference call. That allowed us to hear what the son was saying to his father, and then his father could write a response that we then read back to the son. It was a very lengthy and emotional meeting.

We were able to reassure Edison that although he would be moving to a nursing home, it was primarily for daily medication and nutrition management along with supervision of his personal care. He would still have freedom of movement. He could visit with his son's family often and have access to his cherished books, music and artwork that his son could store in his home. When the time came for more intensive medical care, his son would be right there with him and his medical care providers would be in place.

Edison accepted this plan and agreed to move by April 1. On March 30, his son flew up to Virginia, rented a truck, and with our help, moved his father out of the apartment. Despite driving through a fierce snowstorm, running out of gas, and having Edison's feeding tube become dislodged, they completed their journey.

Best Practices in Care Coordination – A Case Study
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A follow-up call to the nursing home on April 7 indicated that Edison had been admitted and was settling in ... "So far, so good!" On April 18, I received a voice mail from his son saying that his father's overall health had actually improved since placement in the nursing facility, although his motor skill functions were continuing to decline as a result of ALS.

As a result of a great team effort and our care management program, Edison is now in a more secure environment where his physical, medical and emotional needs can be monitored and attended to. He is safe within the reach of his family and for whatever time remains, he will have their love and support...and did I mention... he can still laugh!